STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF COMMUNITY HEALTH
P.O. Box 30763, Lansing, MI 48909
(877) 833-0870; Fax: (517) 373-4147

IN THE MATTER OF:

[redacted] Docket No. 2013-39897 QHP
[redacted]

Appellant
_____/

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and 42 CFR 431.200 *et seq.,* upon the Appellant's request for a hearing.

After due notice, a hearing was held on [redacted]. [redacted] the Appellant, appeared on her own behalf. [redacted]. was represented by [redacted] Staff Attorney. [redacted] is a Department of Community Health contracted Medicaid Health Plan (MHP). [redacted] Grievance Coordinator, appeared as a witness for the MHP.

ISSUE

Did the MHP properly deny the Appellant's request for a referral to a neurosurgeon?

FINDINGS OF FACT

The Administrative Law Judge, based upon the competent, material and substantial evidence on the whole record, finds as material fact:

1. The Appellant is a [redacted]-year-old Medicaid beneficiary and is enrolled in an MHP.

2. On or about [redacted] the MHP received a request from a physician's assistant for a referral for the Appellant to see a neurosurgeon for diagnoses of severe DDD, radiating bilateral arm pain, neck pain. The attached documentation included a [redacted] MRI report, a [redacted] progress note, and [redacted] encounter reports dated [redacted] and [redacted]. (Exhibit 2)

3. On [redacted], the MHP issued a letter indicating the referral request for consultation with the neurosurgeon was denied because the MHP's Determination Procedure for Appropriate Management of Referrals

Related to Neck and Back Pain requires a consult with a Physical Medicine and Rehabilitation specialist prior to approval to a neurosurgeon unless the listed criteria/conditions are met. The available information did not show the Appellant met the criteria/conditions. (Exhibit 1, pages 4-6)

4. On [redacted], the Appellant's doctor issued a referral for the Appellant to a Physical Medicine and Rehabilitation specialist for an evaluation. (Hearing Summary, Member Satisfaction Coordinator Testimony)

5. On [redacted], the Michigan Administrative Hearing System received the Request for Hearing submitted on the Appellant's behalf. (Exhibit 1, pages 1-3)

CONCLUSIONS OF LAW

The Medical Assistance Program is established pursuant to Title XIX of the Social Security Act and is implemented by Title 42 of the Code of Federal Regulations (CFR). It is administered in accordance with state statute, the Social Welfare Act, the Administrative Code, and the State Plan under Title XIX of the Social Security Act Medical Assistance Program.

The Respondent is one of those MHPs.

> The covered services that the Contractor has available for enrollees must include, at a minimum, the covered services listed below. The Contractor may limit services to those which are medically necessary and appropriate, and which conform to professionally accepted standards of care. The Contractor must operate consistent with all applicable Medicaid provider manuals and publications for coverages and limitations. If new services are added to the Michigan Medicaid Program, or if services are expanded, eliminated, or otherwise changed, the Contractor must implement the changes consistent with State direction in accordance with the provisions of Contract Section 2.024.
>
> Although the Contractor must provide the full range of covered services listed below they may choose to provide services over and above those specified. The covered services provided to enrollees under this Contract include, but are not limited to, the following:

- Ambulance and other emergency medical transportation
- Blood lead testing in accordance with Medicaid Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) policy
- Certified nurse midwife services
- Certified pediatric and family nurse practitioner services
- Chiropractic services
- Diagnostic lab, x-ray and other imaging services
- Durable medical equipment (DME) and supplies
- Emergency services
- End Stage Renal Disease services
- Family planning services (e.g., examination, sterilization procedures, limited infertility screening, and diagnosis)
- Health education
- Hearing and speech services
- Hearing aids
- Home Health services
- Hospice services (if requested by the enrollee)
- Immunizations
- Inpatient and outpatient hospital services
- Intermittent or short-term restorative or rehabilitative services (in a nursing facility), up to 45 days
- Restorative or rehabilitative services (in a place of service other than a nursing facility)
- Medically necessary weight reduction services
- Mental health care – maximum of 20 outpatient visits per calendar year
- Out-of-state services authorized by the Contractor
- Outreach for included services, especially pregnancy-related and Well child care
- Parenting and birthing classes
- Pharmacy services
- Podiatry services
- Practitioners' services (such as those provided by physicians, optometrists and dentists enrolled as a Medicaid Provider Type 10)
- Prosthetics and orthotics
- Tobacco cessation treatment including pharmaceutical and behavioral support

- Therapies (speech, language, physical, occupational) excluding services provided to persons with development disabilities which are billed through Community Mental Health Services Program (CMHSP) providers or Intermediate School Districts.
- Transplant services
- Transportation for medically necessary covered services
- Treatment for sexually transmitted disease (STD)
- Vision services
- Well child/EPSDT for persons under age 21

Article 1.020 Scope of [Services],
at §1.022 E (1) contract, 2010, p. 22.

(1) The major components of the Contractor's utilization management (UM) program must encompass, at a minimum, the following:

- Written policies with review decision criteria and procedures that conform to managed health care industry standards and processes.
- A formal utilization review committee directed by the Contractor's medical director to oversee the utilization review process.
- Sufficient resources to regularly review the effectiveness of the utilization review process and to make changes to the process as needed.
- An annual review and reporting of utilization review activities and outcomes/interventions from the review.
- The UM activities of the Contractor must be integrated with the Contractor's QAPI program.

(2) Prior Approval Policy and Procedure

The Contractor must establish and use a written prior approval policy and procedure for UM purposes. The Contractor may not use such policies and procedures to avoid providing medically necessary services within the coverages established under the Contract. The policy must ensure that the review criteria for authorization decisions are applied consistently and require that the reviewer consult with the requesting provider when appropriate. The policy must also require that UM

> decisions be made by a health care professional who has appropriate clinical expertise regarding the service under review.
>
> **....**

Contract, *Supra,* p. 49

As stated in the Department-MHP contract language above, a MHP, "must operate consistent with all applicable Medicaid Provider Manuals and publications for coverages and limitations." The pertinent section of the Michigan Medicaid Provider Manual (MPM) states:

> **6.3 CONSULTATIONS**
>
> Medicaid covers consultations rendered by a physician whose opinion or advice is requested by another appropriate practitioner (e.g., physician, CNM, dentist) for the further evaluation and management of the patient.
>
> *Department of Community Health,*
> *Medicaid Provider Manual, Practitioner Section*
> *Version Date: January 1, 2013, Page 46.*

The DCH-MHP contract provisions allow prior approval procedures for utilization management purposes. The MHP reviewed this prior approval request under the MHP's Operational Policy/Procedure for Appropriate Management of Referrals Related to Neck and Back Pain. The procedure requires a consult with a Physical Medicine and Rehabilitation specialist prior to approval to a neurosurgeon unless the listed criteria/conditions are met:

> **II Procedure Statement**
>
> A. When a referral request for a neurosurgeon or orthopedic surgeon is initiated the Medical Management department reviews the request to determine the urgency of the request. If the request is determined to be non-urgent, the requesting practitioner is informed of this policy/procedure, and is redirected to submit a referral to [Physical Medicine and Rehabilitation "PM&R"]
>
> B. Determination of the appropriateness for a neurosurgeon or ortheopedic surgeon for treatment of neck and back pain is performed as indicated below:
>
> 1. A referral request is considered urgent if clinical documentation demonstrates the presence of 'red flags'

i. **If a 'red flag' exists;** the mandated referral to PM&R is not required; referral to neurosurgeon/orthopedic surgeon is reviewed under standard referral rules (Utilization 27).

ii. **If no 'red flags' documented**, a review of prior referrals/specialty consultations is performed.

2. Prior referrals: verify if the member has a PM&R visit for the same condition identified in the referral to the neurosurgeon/orthopedic surgeon in the last six months.

    i. **If yes**, the mandated referral to PM&R is not required; referral to neurosurgeon/ orthopedic surgeon is reviewed under standard referral rules (Utilization 27)

    ii. **If no**, review present specialty consultations.

3. Present consultations: verify if the member has been under the care of a neurosurgeon or orthopedic surgeon for the condition identified in the referral

    i. **If yes**, the mandated referral to PM&R is not required; referral to neurosurgeon/ orthopedic surgeon is reviewed under standard referral rules (Utilization 27)

    ii. **If no**, PM&R referral is required.

4. If the requesting practitioner does not agree with the requirement for a PM&R referral; the case is forwarded to the Plan Medical Director for review and decision making.

The 'red flag' diagnoses are: cauda equine syndrome; severe neurologic compromise; spine trauma resulting in fracture; and evidence of spinal infection, tumor or malignancy. The 'red flag' symptoms are: reduced or absent lower extremity reflexes; pain worsening at night; spasticity; bowel and bladder disturbances; breathing difficulties; weakness and paralysis; pain in one or both legs that starts in buttocks and travels down the back of the thighs and legs; numbness in groin or area of contact if sitting or numbness in extremities; neck stiffness with fever, chills, headache or elevated WBC, CPR, ESR; lower extremity muscle weakness and loss of sensations. (Exhibit 1, pages 7-9)

These criteria are consistent with the Medicaid standard of coverage to provide appropriate consultations, do not effectively avoid providing medically necessary services and are allowable under the DCH-MHP contract provisions.

It was uncontested that the Appellant had not seen a Physical Medicine and Rehabilitation specialist prior to the request for referral to a neurosurgeon. The Member Satisfaction Coordinator explained that if the information submitted with the referral request had indicate her condition was urgent, the MHP could have approved the referral to the neurosurgeon right away. However, since the submitted documentation did not indicate the Appellant's condition was urgent and the specified criteria/conditions in the MHP's procedure were not met, the MHP denied the referral request to the neurosurgeon at that time. The MHP confirmed that the Appellant's doctor has referred her to a Physical Medicine and Rehabilitation specialist. Accordingly, if that specialist evaluates the Appellant and feels the Appellant's next step should be a referral to a neurosurgeon, or if her condition becomes urgent or meets the listed criteria/conditions, the MHP will approve a referral to a neurosurgeon. (Member Satisfaction Coordinator Testimony; Hearing Summary)

The Appellant disagrees with the denial. The Appellant asserted that if her doctor, who saw her x-rays, did not feel the referral to the neurosurgeon was necessary, he would not have made the referral in the first place. The Appellant has had the pain for over one year. The Appellant went to the Physical Medicine and Rehabilitation specialist, who said she had rheumatoid arthritis and fibromyalgia, and referred her to a rheumatologist. The rheumatologist told the Appellant she needs to have the underlying problems with her neck and back addressed, which is not his area, and she should go back to the Physical Medicine and Rehabilitation specialist. The Appellant has another appointment scheduled with the Physical Medicine and Rehabilitation specialist. (Appellant Testimony)

The documentation submitted with the [redacted] referral request was insufficient to establish the medical necessity of the consultation with a neurosurgeon. The referral request listed diagnoses of severe DDD, radiating bilateral arm pain, neck pain and the [redacted] encounter reports document complaints of back pain and headaches. However, no neck stiffness was documented with the complaint of headaches. (Exhibit 2) The information did not indicate the Appellant's condition was urgent, establish any of the 'red flag' diagnoses or symptoms, or meet the other referral conditions to exempt her from seeing a Physical Medicine and Rehabilitation specialist prior to the referral to a neurosurgeon. The MHP's determination must be upheld based on the information available at that time.

However, a new referral request can be made at any time with supporting documentation, such as the Physical Medicine and Rehabilitation specialist stating he has evaluated the Appellant and feels referral to a neurosurgeon is indicated, that the Appellant's condition is urgent or that she met the criteria/conditions in the MHP's procedure.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that that the MHP properly denied the Appellant's request for a referral to a neurosurgeon.

IT IS THEREFORE ORDERED that:

The Medicaid Health Plan's decision is AFFIRMED.

/s/
Colleen Lack
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

Date Signed: [redacted]

Date Mailed: [redacted]

CL/db

cc: [redacted]

***** NOTICE *****

The Michigan Administrative Hearing System may order a rehearing on either its own motion or at the request of a party within 30 days of the mailing date of this Decision and Order. The Michigan Administrative Hearing System will not order a rehearing on the Department's motion where the final decision or rehearing cannot be implemented within 90 days of the filing of the original request. The Appellant may appeal the Decision and Order to Circuit Court within 30 days of the receipt of the Decision and Order or, if a timely request for rehearing was made, within 30 days of the receipt of the rehearing decision.